COMMENTARY PROVIDED BY
Jeffrey L. Susman, MD, Editor-in-Chief

A physician reportedly ordered that the enoxaparin be discontinued, but the patient received another dose just after she arrived at the second hospital and 3 more doses before the drug was discontinued 2 days later.

Delayed diagnosis renders dominant hand and wrist useless

A WOMAN HOSPITALIZED WITH RESPIRATORY SYMPTOMS was treated and released 4 days later. She returned by ambulance the next day and was readmitted for chronic obstructive pulmonary disease and respiratory failure. She had a history of tobacco use. It turned out she had suffered a myocardial infarction. After a cardiac consultation, she was started on 3 anticoagulants, including enoxaparin.

When her condition failed to improve after 4 days, she was transferred to another hospital. Before the transfer, bruising and slight swelling were observed on the patient's left side and chest, and a physician reportedly ordered that the enoxaparin be discontinued. The plaintiff received another dose of enoxaparin just after she arrived at the second hospital and 3 more doses before the drug was discontinued 2 days later. On the day after admission, the patient's right forearm, her dominant arm, was noted to be swollen, firm, and painful; her torso was bruised. No immediate evaluation was performed.

An orthopedic consultation the following day led to a diagnosis of compartment syndrome. Emergency surgery resulted in loss of muscle and nerves in the arm and chronic pain. The patient also developed anemia, hypovolemic shock, and retroperitoneal hemorrhage requiring a number of blood transfusions. The patient lost almost all function in her right wrist and hand.

PLAINTIFF'S CLAIM The defendants were negligent in failing to promptly diagnose compartment syndrome and subsequent hemorrhaging.

THE DEFENSE No negligence occurred.

VERDICT $1.525 million Ohio verdict.

COMMENT *Subtle and nonspecific findings make compartment syndrome a challenging diagnosis. The combination of extremity pain, swelling, and bruising in the context of anticoagulation should trigger consideration of this condition.*

Failure to suspect endocarditis ends in heart surgery and memory deficit

GENERAL ACHES, FATIGUE, AND OCCASIONAL FEVER of 102.5°F led a 43-year-old woman to seek treatment at a local clinic. The nurse practitioner who examined her suspected influenza. Six days later the patient returned, complaining that her symptoms were making it difficult to care for her 4 children. She didn't have a fever at the time. The nurse practitioner suggested that the woman might want to go to the local hospital for an examination; she also said she could prescribe oral antibiotics to see if they helped. The patient chose the antibiotics.

Her symptoms improved over the next week but then reappeared, prompting her to return to the clinic with complaints of headache, muscle aches, fatigue, chest tightening, an unproductive cough, and night sweats so severe she had to wrap herself in a towel to avoid soaking her bed. Although she was still having regular periods, a physician told her she was probably premenopausal. He also told her that overweight people often sweat at night and attributed her fatigue to her 4 children. He prescribed rizatriptan on the theory that the headaches might be migraines. Because the woman didn't have a fever at the time of the visit and had just finished a course of antibiotics, the physician said he was sure that she didn't have an infection.

After 6 days with no improvement, the patient went to a hospital emergency department (ED) for a complete checkup because she was planning to drive to Arizona with her family and wanted to make sure she was all right before leaving. The ED physician ordered scans, a spinal tap, and blood tests; he diagnosed a viral infection.

Three days later, the patient went to the

CONTINUED ON PAGE 500

The cases in this column are selected by the editors of *The Journal of Family Practice* from *Medical Malpractice: Verdicts, Settlements & Experts,* with permission of the editor, Lewis Laska (www.verdictslaska.com). The information about the cases presented here is sometimes incomplete; pertinent details of a given situation may therefore be unavailable. Moreover, the cases may or may not have merit. Nevertheless, these cases represent the types of clinical situations that typically result in litigation.

CONTINUED FROM PAGE 492

Her symptoms included night sweats so severe she had to wrap herself in a towel to avoid soaking her bed. Although she was still having regular periods, a physician told her she was probably premenopausal.

clinic, accompanied by her entire family, to find out the results of the blood tests. She still had symptoms and had developed a swollen, tender sternum. The nurse practitioner noted a positive culture result for *Streptococcus veridans* on the test report; she allegedly told the patient, in the presence of her 10-year-old son, that it must be a skin contaminant. She advised the patient to go on vacation and have additional blood work if she didn't feel better.

The nurse practitioner gave the patient another pack of oral antibiotics in case she had a lingering low-grade infection. The patient also received another prescription for rizatriptan and an acetaminophen and oxycodone prescription for pain.

The nurse practitioner claimed that she suggested that the patient could stop by the hospital for a blood test before leaving on vacation, but the patient denied that the nurse made the suggestion, and no notes supported the claim. The oral antibiotics relieved the patient's symptoms only temporarily. The family cut short their vacation so the patient could return to the clinic, where she received another ineffectual antibiotic. When her condition continued to deteriorate, her husband took her to the ED of a larger hospital in the area.

The ED physician diagnosed subacute endocarditis, which was confirmed by subsequent tests. Testing also identified a bicuspid aortic valve, which increased the patient's susceptibility to endocarditis. She was started on appropriate intravenous antibiotics and improved initially.

The patient subsequently noticed red patches on her hand and forearm. She also experienced problems with mental processing. She returned to the hospital, where a scan showed increased vegetative growth on her aortic valve. Pieces of the growth were breaking off, causing embolic injury to the patient's brain, hand, and other areas of her body. The patient underwent open heart surgery to replace the aortic valve and prevent further embolic injury. She continues to suffer from significant short-term memory loss and will require warfarin for the rest of her life to prevent blood clotting.

PLAINTIFF'S CLAIM The patient should have been referred earlier for a complete workup, and the nurse practitioner should have taken seriously the culture showing *S veridans*. The nurse practitioner was mistaken in thinking that *S veridans* was found on the skin. Had she looked it up, which she should have done, she would have discovered that the organism is the most common bacterial cause of subacute endocarditis.

The patient had the classic symptoms of subacute endocarditis. The delay in diagnosis allowed bacteria to build up on her aortic valve, forming a biofilm barrier that inhibited the effect of the IV antibiotics and the body's natural defenses and precipitated the embolic injury.

THE DEFENSE The patient was responsible for the delay in diagnosis, especially in light of the fact that she had a nursing background. Any negligence on the part of the nurse practitioner had no effect on the outcome.

VERDICT $1 million Washington settlement.

COMMENT *Subacute bacterial endocarditis remains a challenging diagnosis with potentially devastating consequences. Be on the alert for this subtle masquerader.* **JFP**